Case Number:	CM15-0221506		
Date Assigned:	11/18/2015	Date of Injury:	07/27/2011
Decision Date:	12/24/2015	UR Denial Date:	11/02/2015
Priority:	Standard	Application Received:	11/11/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: Massachusetts
Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 53 year old male, who sustained an industrial injury on 7-27-2011. The injured worker was being treated for posttraumatic cervical spondylosis, cervical stenosis, right sided C7 radiculopathy, and cervicalgia. Treatment to date has included diagnostics, left hand surgical repair for lacerations, ocular surgery with hardware placement and subsequent removal, acupuncture, chiropractic, epidural steroid injections (most recent 6-15-2015 and 7-27-2015), and medications. On 10-08-2015, the injured worker complains of pain in his shoulder, arm, head, and neck. His neck pain radiated to his right finger. Pain was rated 7-8 out of 10. He reported significant problem with dropping objects and that symptoms radiated in a C7 distribution on the right. Balance issues were reported as well. His past medical history included sleep apnea, hypertension, osteoarthritis, headache, depression, and anxiety. Medications included Buspirone, Bupropion, Gabapentin, and Norco. Exam of the cervical spine noted motor strength 4 of 5 in the right C5-6, C7, and T1. He had numbness to light touch in the C7 distribution. Deep tendon reflexes were absent in the right biceps and triceps, along with in the bilateral patella. Spurling test was positive on the right. X-rays were taken and showed "questionable type 1 odontoid fracture that is healed" and "C4-5 and C5-6 anterolisthesis and C6- 7 disk height loss. Magnetic resonance imaging of the cervical spine (12-19-2013) showed "C6- 7 paracentral disk osteophyte complex that extends into the neural foramen causing moderate to severe stenosis" and "at C3-4, there is a right-sided broad-based disk osteophyte complex with mild stenosis". Magnetic resonance imaging of the cervical spine (4-29-2014) showed "moderate stenosis at C5-6, diffuse congenital narrowing, and C6-7 moderate stenosis".

Electromyogram and nerve conduction studies were reported as negative for any radicular injury. The treatment plan included repeat magnetic resonance imaging of the cervical spine to evaluate the degree and nature of his stenosis, noting that he was showing progressive worsening of myelopathic symptoms. Also recommended was computerized tomography of the cervical spine without contrast to assess for areas of old fracture, and to obtain a better view of the bony anatomy. The treating physician noted that he failed "multiple conservative approaches" and was a candidate for surgery, likely an anterior cervical discectomy and fusion. On 11-02-2015 Utilization Review non-certified a request for computerized tomography of the cervical spine without contrast.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

CT scan cervical spine without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic), computed tomography (CT).

Decision rationale: The claimant sustained a work injury in July 2011 when, while working on a mechanical wheel, a grinding stone exploded striking his face and hand. He sustained significant left hand lacerations and underwent enucleation of the right eye. The requesting provider saw him for an initial evaluation on 10/08/15. He was having significant problem with dropping objects and was having radiating symptoms in a right C7 distribution. Treatments had included multiple epidural injections with limited relief and chiropractic manipulation. Prior testing had included MRI scans of the cervical spine in December 2013 and April 2014. Electrodiagnostic testing is reported as having been negative. Physical examination findings included decreased cervical spine range of motion. There was decreased right upper extremity strength and decreased sensation in C7 distribution. Right biceps and triceps reflexes were absent. Right Spurling's testing was positive. An x-ray of the cervical spine including flexion and extension views showed findings of questionable type I odontoid fracture that had healed. There was anterolisthesis at C4/5 and C5/6 and loss of disc height at C6/7. Authorization was requested for another MRI scan and for a CT scan of the cervical spine to assess the area of possible previous fracture. A CT scan of the cervical spine can be recommended to evaluate for a pars defect not identified on plain x-rays or to evaluate a fusion after obtaining plain x-rays, which do not confirm a successful fusion. In this case, there is no acute injury or history of a cervical fusion. There are no reported findings of instability or reports of pain with neck movement. The requested CT scan is not medically necessary.